

# **MENTAL HEALTH AND RETARDATION**

"WE MUST ALLOW THE  
HANDICAPPED PERSON  
TO EXPERIENCE AS  
NORMAL A LIFE AS POS-  
SIBLE."

**A POSITION PAPER ON  
MENTAL HEALTH  
AND MENTAL RETARDATION**

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## MENTAL HEALTH AID RETARDATION

Minnesotans can look back "with satisfaction on the decade of the 1960's as a period of great progress in the field of mental health and mental retardation. Achievement has been especially noteworthy during the last four years of the decade under the LeVander administration.

The most striking advances can be noted in the rapid development of community programs. Since the enactment of the Mental Health Act in 1957, twenty-five Community Mental Health Centers have been established to serve local communities throughout the state. Governor LeVander asked for, and received from the Legislature, substantial budget increases for community centers. Included among the increases was a *160%* increase for mental health centers in four years.

Equally impressive has been the development of local Day Activity Centers (DAC's) for the retarded. Day Activity Centers, one of Minnesota's most successful programs providing service to mentally retarded children and adults in their home communities, were begun in 1961 when the Legislature appropriated \$36,000 in matching funds for a pilot project. The project served eighty children and adults in seven state centers.

In 1967, under Governor LeVander, the Day Activity Centers were officially begun. Today, over 1,490 students are using 86 centers

supported by funds budgeted by the 1969 Legislature which doubled the 1967 appropriations. Under this program, many people are receiving training and education for the first time in their lives and as a result, live at home rather than in a state institution.

I have been actively involved in this area the past several years by supporting laws concerning mental illness. I have been State Chairman for the Minnesota Association for Retarded - Children's Institution Tour, a committee consultant for Minnesota's Mental Health Planning Council, and legal counsel for the Minnesota Association for Mental Health.

The high priority given to mental health and retardation during the LeVander administration is evident in the enactment of statutes which support and encourage the development of locally oriented residential care and other services to the disabled. For example, the state has begun to pay a portion of the cost-of-care for mentally retarded children receiving treatment in non-state institutions. In addition, under the LeVander administration, work activity programs for the mentally ill and retarded were established at state institutions, and special education classes were considerably expanded.

I praise these accomplishments as dramatic steps away from the 19th century practice of confining the mentally ill and the mentally retarded to massive, dehumanizing state hospitals.

Between 1960 and 1970, the number of mentally ill and mentally retarded persons in our state institutions has decreased by a remarkable 38.9%.

The impact of community programs is clearly seen in a lessened demand for state care for the retarded. There are currently 1,746 fewer mentally retarded persons in state hospitals than in 1960. This represents a decline of 27%. Current theories of care for the mentally handicapped point strongly to the advantages of this shift from large institutions to community-based centers.

The advantages of community facilities for the mentally handicapped are significant. Since the mentally ill or retarded person remains close to home, his family can take a more active role in his care. The family can not only assist personally, but also financially, thus providing savings to the state. The emphasis of community-centered care is less impersonal, emphasizing instead the dignity of every person and his right to receive appropriate training and education to develop his maximum potential and independence.

Community-based services mean not only better care for the mentally handicapped, but also savings to the taxpayer. Already existing professional and volunteer medical services in the community can be utilized, as can schools, parks and movies. It has been estimated that the average cost of a Day Activity Center student

is \$1,000 per year, while residence in a state institution costs \$4,750 per year.

Our goal in formulating any program for the mentally handicapped must be "normalization". We must allow the handicapped person to experience as normal a life as possible. In my opinion, facilities for the mentally handicapped should be near the person's home, conform in size and structure to what is normal for non-handicapped persons, and never be developed for a larger number of people than the community can readily assimilate into its everyday life style.

Ideally, we should develop a framework of community-based programs, retaining only a few state institutions to provide specialized services. We must move away from approaching the problems of the mentally handicapped in terms of numbers. Our programs must provide for the needs of the mentally ill and retarded, emphasizing rehabilitation and treatment goals.

As I have pointed out, we have made great progress toward this ideal of community-based programs. One might ask, "What is left to be done?" My answer can only be ~ "a great deal, if we truly desire to treat the mentally handicapped in the best, most human and effective manner."

Appropriations in the state budget show that we still spend a disproportionate amount of money for large institutions - \$99 million is appropriated for our institutional system., and only \$10.5 million for the community system.

Granted, we can not suddenly cut off all funds for large hospitals, but this trend in spending must be reversed. In order to expand community-oriented services, funds must be taken from large institutions. To that end, I favor no further investment of funds in the state hospital system, except that necessary to meet health, safety and immediate program requirements. My goal is to provide for an orderly transition from large institutional programs to those centered in local communities.

If we successfully reverse the spending pattern, we can begin to face some of the problems and deficiencies still existing in our services.

In the field of mental retardation, several problems need our immediate attention. There is currently a shortage of residential services in communities. Despite the reduced number of admissions to state hospitals, there has been only a slight increase in the capacity of the community residential facilities for the mentally retarded. No new facilities have been opened since 1965.

Thus, most handicapped persons returning from state institutions are adults forced to live in boarding care homes which do not

adequately provide for training, counseling, and recreational programs.

Although greatly expanded during the last decade, Day Activity Centers are still not available to all persons who could benefit from them. A December 1969 study indicated that 3,581 Minnesotans would be best served by Day Activity Centers, but only 1,304 could make use of existing facilities. This means that 2,277 handicapped persons were being deprived of adequate treatment.

Moreover, there are still 16 counties lacking these Day Activity Centers, and many existing centers are remote and unavailable because they are not incorporated into the public educational system.

Other programs are still not meeting the demand. Over 12,000 mentally retarded persons considered educable are not currently enrolled in special education classes. Our existing sheltered workshop program is meeting only 25% of the need. This last program is worthy of particular note. Eighty-five percent of mentally retarded persons can be employed if given the proper education and training. This aspect of treatment is worth stressing because funds spent for education and training are an investment which will be repaid by the taxes of employed citizens.

In order to maintain Minnesota's position as a leader in care for the mentally retarded and to promote and develop even better services for our fellow citizens, I am today proposing the following program:

1. EXPANSION OF STATE SUPPORT FOR DAY ACTIVITY CENTERS

This highly successful program should be expanded by an increase in state funds sufficient to meet the needs of centers now operating and to promote the establishment of new centers. We are now meeting about 40% of the need for Day Activity Center programs, and centers are being funded at only 40.00% although 50% is allowed by law.

Funds should also be made available to expand the consultation services of the Department of Public Welfare to these centers and rent for such facilities should be subject to state reimbursement.

Furthermore, the law should be amended to allow any school age mentally retarded child who has been excused or excluded from public school under a mandatory special education law to use Day Activity Centers.

2. DEVELOPMENT OF COMMUNITY RESIDENTIAL CENTERS

I propose that the Legislature set up a State Matching Development Fund for the construction and development of a



state-wide system of community residential centers with the state supplying 75% of the cost. The program I am advocating could be adequately funded if we reverse the present appropriations for state institutions and community centers. The decreased funds for large hospitals would still allow the hospital system to meet immediate needs while a plan is formulated to gradually phase out most of our state institutions in favor of local services.

3. COST-OF-CARE

Presently, the state provides 50% of the cost of caring for a retarded person in a non-state institution. The county provides 40% and the family the remaining 10%. Counties lacking funds are reluctant to place citizens in such institutions and favor state institutions where county funds are not required. Thus, the welfare of the patient who might be best served in a private facility becomes secondary to the county's budget.

I would propose that the state law be amended to allow the state to provide 90% of the cost, with the family maintaining responsibility for the remaining 10%. In this manner, care of the patient would be the prime consideration in determining institutional placement.

4. SPECIAL EDUCATION

Special education services must be equally available to all of Minnesota's retarded children. Therefore, I advocate mandatory education for all school age educable and trainable children. To meet the demand, we must also increase aids for Special Education personnel.

5. VOCATIONAL REHABILITATION AND SHELTERED WORKSHOPS

The importance of these programs to the general public, as well as to the mentally retarded, can not be overly emphasized. I call upon the Legislature to increase appropriations so we can expand existing facilities and build others.

6. DIVISION OF MENTAL HEALTH

I propose that a separate Division of Mental Health be created within the Department of Public Welfare. This division would be charged with the responsibility of administering state programs for the mentally handicapped.

Turning to programs for the mentally ill, we must strive to solve problems still remaining to improve upon the noteworthy progress in this field.

Studies show that 10% of U.S. citizens need some kind of psychiatric treatment. This means that approximately

37,700 Minnesotans would benefit from such help. A 1968 study revealed that 50,000 children in Minnesota were disturbed. Are we providing them with adequate and appropriate care?

I wish to stress once again that building big institutions is not the answer. We must treat the mentally ill in local communities through programs such as Community Mental Health Centers.

Several changes should be made in relation to these all-important health centers and in other areas of mental health services. As Governor, my proposals in this area would include:

A. Expansion of the Community Mental Health Centers.

These Centers should receive a greater proportion of our budget so that they can be improved and expanded.

Major emphasis in the Centers should be placed on diagnostic and treatment services. In the Mental Health Act of 1957, Which is the Enabling Act for the Community Mental Health Centers, five program services were designated. These include prevention of mental illness, mental retardation and other psychiatric disabilities, education of the public, consultative services to local agencies as well as out-patient diagnostic and treatment services.

Because Centers have difficulty maintaining a full complement of staff to provide all five services, I favor placing the major emphasis on diagnosis and treatment. This out-patient service allows many more patients to be treated in their own communities, rather than in a state hospital.

Furthermore, the rehabilitation services of the Centers should be extended to include vocational rehabilitation as well as social and recreational services. In the long run, this would save the taxpayer money by helping to make more citizens self-supporting.

I propose that the 1957 Enabling Act be changed to allow Community Health Centers to make contractual arrangements for psychiatric services and for the hospitalization of patients with hospitals in their own area. This would improve mental health care by allowing mentally ill patients to be cared for in their own communities.

Finally, the large number of children needing mental health care makes it imperative that the Community Centers place high priority on evaluation, diagnosis and treatment of children.

#### B. Coordination of Services for Mentally Disturbed Children

At the present time, there are numerous public and private

services working with children, but coordination among these services is poor. To bring about maximum use of existing facilities, and to determine the most effective additional services, coordination is imperative. This could be provided by the existing Community Mental Health Centers, or by a newly created Division of Mental Health.

C. Additional Manpower in the Mental Health Field

The manpower shortage in this crucial field is acute, and will become more serious as we expand our services. To alleviate this problem, innovations and experimentation should be undertaken by the traditional professions to expand and develop auxiliary personnel.

Indigenous personnel could be trained by the Division of Mental Health and Community Mental Health Centers. These para-professionals could do tasks of referral, individual and group counseling, pre and post hospital, legal, social and employment help, family assistance and assistance with financial needs. They could also work with guidance counselors, principals and teachers dealing with problem children and act as a liaison between mental health services and other public and private agencies.

If government is to be prepared for the influx of these new people and professions, government legislation,

regulations, hiring practices, then job descriptions must be reoriented to provide for the recruitment and training of these employees. State merit systems and Federal Services must be prepared to accomodate these new mental health workers.

D. Improvement of Legal Services for Potential or Actual State Hospital Patients

The 1967 Minnesota Hospitalization and Commitment Act, which I drafted, elaborated the commitment procedure, clarified the rights of the proposed patient, encouraged his local hospitalization pending the commitment hearing, introduced the hospital review board concept, and provided more effective restoration procedures. This act was an extremely significant step toward guaranteeing the legal rights of the mentally ill. To further protect mental patients, I consider it imperative at this time, to improve the range of legal services available to potential or actual state hospital patients.